U.S. Department of Labor

Office of Administrative Law Judges
50 Fremont Street - Suite 2100
San Francisco, CA 94105

(415) 744-6577
(415) 744-6569 (FAX)

Issue Date: 30 November 2004

OALJ Case №.: 2003-LHC-1097
OWCP Case №.: 14-131632

In The Matter Of:

CHRISTOPHER EARNSHAW,

Claimant,

vs.

SEA-LAND SERVICE, INC.,

Permissibly Self-Insured Employer.

Appearances:

Kenneth Kirk, Esq.
Attorney for Claimant

Matthew D. Regan, Esq.
Attorneys for Respondent

Before:

William Dorsey
Administrative Law Judge

DECISION AND ORDER

Christopher Earnshaw (Claimant) seeks disability benefits, medical care and penalties for late benefit payments from his Employer, Sea-Land Service, Inc. (Sea-Land), under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901 *et seq*. (the Act.

The trial was held on February 13, 2004, in Sacramento, California. The parties stipulated that: (1) they are subject to the Act; (2) Claimant injured his left knee on October 11, 1999, while in the scope and course of his employment; (3) notice, filing, and controversion of the claim all were timely; (4) Claimant's average weekly wage at the time of the injury was $985.08 per week, so his weekly compensation rate is $656.72; (5) Employer paid temporary total disability compensation at that rate from October 27, 1999 to June 29, 2000, the date when

Employer contends his knee reached maximum medical improvement; (6) Claimant had an earning capacity of at least $330.00 per week from the date of maximum medical improvement for the knee, computed as $8.25 per hour x 40 hours (although Sea-Land believes his earning capacity is higher) ; (7) Sea-Land made a schedule-based payment of permanent partial disability compensation for a 12% impairment of Claimant's left lower extremity after the knee was said to have reached maximum medical improvement, at the stipulated average weekly wage, that totaled $14,916.94; and (8) Claimant does not contend he is due any additional temporary total disability payments for the period before June 29, 2000. *See* the trial transcript (TR) at 7 to 12. The evidence supports these stipulations, so I accept them.

The Claimant's Exhibits (CX) 1 through 9 were admitted, as were Employer's Exhibits (EX) 1 through 32. Some duplicate exhibits were only received once. CX 1 to 3, the depositions of Lisa Hardin (the physical therapist), Benjamin Ling, M.D. (the treating knee surgeon), and Christopher Molitor, M.D. (the treating back specialist) also serve as EX 25, 28, and 27 respectively.

After he fell from a large piece of machinery, Claimant complained about knee and left hamstring pain during his first visit to his treating physician, and later of back pain. His knee surgeon referred him to a spine specialist who diagnosed lumbar strain, an annular tear, and disc herniation with S-1 radiculopathy. Employer erroneously rejected the diagnosis that the back condition was related to the fall, denied medical care for the back, and unilaterally restricted Claimant's access to physical therapy prescribed for the knee. Claimant has not reached maximum medical improvement for his combined injuries, and remains temporarily totally disabled. The payment Employer made for the 12% permanent partial disability to the knee computed by its medical examiner (which it later disavowed as an overstatement of the disability) should be treated as an advance on the temporary total disability payments it owes. Claimant is entitled to interest on unpaid installments of compensation, and to costs and attorney's fees, but not to any statutory penalties.

I. Findings of Fact

At the time of his injury, Claimant was a 29 year old man who stood 6 feet 4 inches tall and weighed 220 pounds. He had worked as a longshoreman for approximately 8 years at the remote port of Dutch Harbor, Alaska in the Aleutian Islands, where much fish is landed. He held a Class B registration as member of the ILWU. TR at 23-25. During that longshore career he worked as a top pick operator (a type of mobile crane), truck driver, forklift operator, loader operator, checker, warehouseman, and "longshoreman," the term used by employers and union members in the Dutch Harbor area to describe heavy, unskilled general labor. TR at 103-05.

A. Claimant's Fall and Treatment in Alaska

In the seasonal darkness on the morning of October 11, 1999, Claimant climbed up to a top pick's cab to start it, using the two ladders that are built into it. He caught his foot on a rung on his way down and fell to the ground, landed on his left knee on rocky ground, and fell to his side. TR at 36-40, and EX 19 at 213, 215 (top pick photos). Within an hour or so a physician's assistant at the Iliuliuk Clinic, James Hickman, saw him. EX 1 at 4. No general practice or other physician is available in the Dutch Harbor/Unalaska area, much less an orthopedic or other

specialist. Claimant told the clinic nurse and Mr. Hickman that he had fallen about six feet, landed on his left knee, and was feeling pain deep inside the knee. Mr. Hickman found tenderness over Claimant's patella, thought the knee looked normal, and read no injury in the x-rays taken of the knee. He believed Claimant had suffered a knee contusion, for which he prescribed ice, elevation, Naprosyn, Tylenol No. 3, and advised Claimant to take the next two days off work. EX 1 at 3.

Claimant walked without pain, stiffness, or weakness, when he returned to care on October 13, 1999, asking for authorization to return to work. EX 1 at 2-3. Physical examination notes recorded minimal tenderness over the inferior patella with some crepitus (*i.e.,* grinding sounds during movement) as the knee went through its range of motion. Mr. Hickman thought this came either from inflammation or from a problem in the cartilage. He diagnosed a "resolving knee/patella contusion," and released Claimant to full-duty work with instructions to return to care as necessary. Claimant worked seven days during the period from October 17, 1999 through October 25, 1999, but found his knee pain became too intense to continue. TR at 40-41; RX 16. He complained of "shooting pain" under the left patella when he returned to the clinic on October 27, 1999. EX 1 at 2. A prompt return to work, which the patient is unable to sustain, commonly occurs with knee and back injuries. EX 27 at 17-18. Mr. Hickman saw no abnormalities on that re-examination, but referred Claimant for an evaluation by an orthopedic specialist, advising him not to return to work until after that exam. Any specialty exam required travel to one of the larger cities in Alaska or to the continental United States.

B. Claimant's Knee Surgery and Post-op Care in California

Mr. Earnshaw left Dutch Harbor for the Placerville, California area, where his parents reside and he grew up. He chose to be treated by Benjamin Ling, M.D., an orthopedist who specializes in sports medicine, especially elbow and knee injuries. This was Claimant's first examination by a fully qualified physician after his fall. Office records show that at this initial visit on November 23, 1999, Claimant told Dr. Ling that:

> "on 10/11/99 [he] caught his foot wrong and fell about 7 feet down some stairs. After that he had left posterior knee pain and then about three weeks ago started developing . . . posterior thigh pain on the same side. Initially he was . . . off work for four days and then went back for a week, then has been off since 10/27/99. He has no previous history of knee or thigh problems. He tried some Naprosyn with minimal benefit. He feels a pop and click at times and a catching sensation [in the left knee]." EX 2 at 47.

Dr. Ling recorded a lack of 10 degrees of flexion in the left knee, found the lateral and medial joint lines were tender, that Claimant exhibited positive lateral meniscal signs[1] and complained of "posterior mid-hamstring" pain when that area was palpated. The meniscal or chondral lesion in the left knee and left hamstring strain would be treated by bringing Claimant to outpatient arthroscopic surgery, while on temporary disability from longshore work. *Id*. The

[1] A sign is an anatomical or physiological abnormality a trained observer can see, in contrast to a symptom, which is a patient's subjective description of his condition.

findings Dr. Ling made are more detailed and record more limitations than Mr. Hickman reported when he examined Claimant in Alaska. The hamstring pain was present from the outset of Dr. Ling's care, after beginning three weeks earlier, which would have been about the time Claimant left Alaska.

Several days later, Employer authorized an MRI of Claimant's knee to investigate any injury to the meniscus. Dr. Ling, however, took Claimant directly to arthroscopic surgery on December 10, 1999. EX 2 at 38. During the procedure he observed chondromalacia[2] in the central portion of the left patella, and in the medial compartment; grade II to III chondromalacia of the lateral 20% of weight bearing portion of the medial femoral condyle; and more grade II to III chondromalacia involving "approximately 5% of the anterior medial portion of the medial tibial plateau." The medial meniscus was not affected. EX 2 at 40. Dr. Ling shaved the damaged cartilage "to debride the medial femoral condyle, [the] medial tibial plateau, and then the patella," and discharged Claimant with a prescription for Vicodin. *Id*. at 42.

The "healing left knee chondral lesion" caused pain as the knee was taken through a range of motion from 0-90 degrees during the first post-operative visit on December 21, 1999. RX 2 at 35. Dr. Ling prescribed joint supplement medications, continued protection of the knee and extended Claimant's temporary disability. At the second follow-up visit Claimant described "stiffness and [knee] pain after walking about a mile; posterior pain." EX 2 at 34. Dr. Ling found "close to full" range of motion and no swelling that day, and diagnosed probable overuse of the knee, plus hamstring strain. His prescribed and arranged for physical therapy at Mother Lode Physical Therapy for the knee three times a week for two weeks, then twice weekly for another two weeks, and "continued TD [temporary disability] for 8 weeks." *Id*. at 33. At that point the focus of concern was the recent knee surgery, the back did not yet loom very large in his condition.

The pain drawing Claimant completed at the outset of his knee therapy showed knee rather than hamstring pain. Lisa Hardin of Mother Load Physical Therapy did the initial evaluation, finding that Claimant had: (1) a diminished range of knee motion (his knee range of motion was from 15-125 degrees); (2) knee edema (the left knee was one centimeter larger in circumference); (3) a loss of functional mobility, with difficulty "getting off floor, walking, stairs, squatting, kneeling and sleeping"; and (4) weakness of "… left lower extremity [LLE] especially the VMO [vastus medialis obliquus]." EX 6 at 111. She planned to treat Claimant using "… modalities, soft tissue mobilization, stretching, strengthening and home exercise program." *Id.*

Thirteen physical therapy sessions in January and February caused Claimant much back pain, however. In her March 1, 2000 report to Dr. Ling, Ms. Harden emphasized Claimant's moderate to extreme low back pain, which she believed was causing referred pain in his left lower extremity. EX 6 at 103. He still could not bear weight fully on the left leg, but the therapy had reduced the frequency of hamstring muscle spasms. The back pain interfered with exercises

[2] Chondromalacia encompasses a range of pathology to the cartilage present at the surfaces where joints glide against one another, or articulate, such as in the knee. At Grade II the cartilage frays into an irregular surface, at Grade III fissures extend through its thickness to the subchondral bone. Grade III and greater chondromalacia can cause pain, swelling, crepitus or the joint to give way. EX 8 at 140.

meant to strengthen the knee. *Id*.

After he reviewed this report Dr. Ling referred Claimant to a spine specialist, Christopher Molitor, M.D., for a back evaluation, in an effort to enhance Claimant's success in therapy for his knee. EX 2 at 33, EX 6 at 103. After he received Dr. Molitor's report, Dr. Ling believed that the back problem, including the posterior thigh (hamstring) pain was related to the fall, and Claimant's back and the knee both required treatment. EX 2 at 31. The insurance adjuster's response to Dr. Molitor's findings was to controvert Claimant's entitlement to treatment for the annular tear. *See* Form LS-207 (a notice of controversion) dated April 4, 2000 at EX 27, internal Ex. A at 9. Dr. Ling advised the insurance adjuster in a letter of May 1, 2000 that the two conditions were interrelated. EX 2 at 28-29. In his response to an inquiry from Employer's medical care manager on May 11th, he held to his view that Claimant's fall caused the back injury, that the knee required aggressive physical therapy, and that Claimant would not "progress in regards to his left knee until his back is stabilized." EX 2 at 28.

The course of physical therapy Dr. Ling ordered ended prematurely in early June after the adjuster handling the claim took it on herself to limit the knee therapy. The injury occurred in Alaska, and worker's compensation practice there limits how frequently an injured worker may receive physical therapy at an employer's expense. *See* Alaska Stat. § 23.30.095 (2000) and Alaska Admin. Code tit. 8 § 45.082(f) (2004).

Claimant's recovery from the knee surgery was limited by his inability to perform the increasingly more strenuous exercises the therapy plan contemplated. The therapist believed nerve pain referred from the back to the left lower extremity kept Claimant from doing leg extension exercises. EX 25 at 56. He exhibited difficulty arising from the floor, his gait was abnormal going down stairs, and he felt pain when the therapist pressed on his hamstring. *Id*. at 57. At times his left leg would go numb as he laid on his right side, and he could not fully extend the left knee due to the strain that placed on the sciatic nerve. *Id*. at 77-7880. Hamstring nerve pain and low back pain interfered with adding resistance training, adding weight to the exercises he could do, and with strength training. *Id*. at 66, 70, 74, 85-86. The therapy notes in April show continuing hamstring pain, but consistent attempts to continue with his therapy, which included bicycle riding. *Id.* at 82. By April 24 significant pain was causing him difficulty sleeping. Ms. Hardin believed Claimant had been making a genuine effort in therapy, and would have progressed if he had more therapy to strengthen his weak quadriceps. *Id*. at 90-91. Claimant continues to experience knee pain to this day, in part because he has never had the therapy his surgeon prescribed.

When Employer's insurance adjuster ceased authorizing therapy as Dr. Ling prescribed it in early June, she knew that Alaska's frequency of service limits were inapplicable to claims for longshore medical benefits. TR at 148, 150. The adjuster's position was that the physical therapy was being prescribed for the back as well as the knee, but refused to fund treatment for the back. TR at 151-52. I infer that the cut-off was a response to Dr. Ling's letters of May 1 and 11, 2000 and to Dr. Molitor's report. The limitation was imposed before any defense examiner declared Claimant's knee had reached maximum medical improvement (Dr. Ling certainly never found that Claimant had done so).

The adjuster never spoke directly to Ms. Hardin when she limited physical therapy for the knee on June 8, 2000. The therapy firm understood her message as a rejection of payment for any more physical therapy, not a reduction in its frequency, so it ceased. EX 25 at 96, & internal exhibit A, entry for June 8, 2000; see also EX 6 at 91. The adjuster never spoke or wrote to Dr. Ling, the prescribing physician, to tell him of her decision to limit the rehabilitative treatment Employer would pay for. He too was left with the impression that authorization for physical therapy had been refused, not limited. EX 28 at 25-26. The Employer's implication that Claimant shares blame for the lack of clarity about whether physical therapy had been rejected outright or merely limited is unpersuasive. Indulging an assumption the adjuster had any role in countermanding a surgeon's prescription for therapy, she failed to deal directly with the prescribing physician, or even the physical therapist. She filed no notice of controversion about the therapy. Once the misunderstanding was discovered in trial preparation, Employer did not re-authorize the therapy that Dr. Ling wanted; it continued to maintain that any back problem was not covered. Any fault is Employer's, not Claimant's. Neither the Act, the regulations nor case decisions limit an Employer's liability for § 7 medical care because the worker failed to pay from his own pocket for physical therapy the treating surgeon prescribed but the employer denied.

When formal therapy ended Claimant still could not fully extend his left knee, or bear full weight on his left leg, and had "severe low back pain which limited all activities such as sitting, standing and walking." EX 6 at 89. Dr. Ling's recommendation then was that Claimant be treated for his lumbar disc disease, and temporary total disability be continued due to the ongoing leg and low back pain. EX 2 at 26. Exasperation is a subtext in Dr. Ling's November 7, 2000 note. He wrote that Claimant still had weakness in flexion and extension of the left knee, persistent knee pain and increasing back pain, but no approval for treatment, which would prolong the rehabilitation. He recommended resumption of the physical therapy "as soon as possible," but none was reauthorized. EX 2 at 25. In a longer report dated November 19, 2000 he characterized Claimant as "significantly disabled with very limited ability to do lifting, squatting, bending, and prolonged standing or walking," due to the fall, and recommended that when Claimant attained maximum medical improvement after aggressive physical therapy for his back and knee was completed, a work capacity evaluation be done. EX 2 at 24.

Nothing happened medically for about a year, because authorization for medical care ceased in late June 2000 when a defense examiner declared Claimant's knee had reached maximum medical improvement. When Dr. Ling next saw Claimant, he found a small atrophy of about 1 cm. of the thigh muscle (measured at 5 cm. above the superior pole of the patella), limited back flexion and extension with pain, a positive straight leg raise test on the right and left when the leg reached 40 degrees, and motor weakness in the areas served by the L4, L5 and S1 nerve roots on the left. Once again Dr. Ling sought aggressive physical therapy for the back and knee, which he anticipated would last 4 to 6 months, with the hope that Claimant then would be able to return to employment. EX 2 at 23. Eighteen months later, Dr. Ling recorded that on examination Claimant's left knee had nearly full range of motion, but those movements caused him back pain, straight leg raise tests were positive when he was sitting and lying down, he had very limited extension and lateral flexion, and tenderness when the lower spine was palpated. There were subjective complaints of left knee pain, and pain in the low back running down the left leg. Walking tolerance was 10 minutes, sitting tolerance was half that. The treatment recommendation in this final report remained for aggressive back and knee physical therapy; due

to the lengthy denial of treatment, rehabilitation was likely to take a long time, and be less successful than if it had been provided timely. Dr. Ling believed Claimant unemployable due to intolerance for sitting, limited tolerance for standing and walking, and inability to lift, pull, push, squat, climb or repetitively turn. EX 2 at 22.

Dr. Ling does not believe Claimant has reached maximum medical improvement, or "permanent and stationary" status, as California practice refers to it, or that he is ready to return to work. EX 28 at 21; EX 2 at 22. The denial of the therapy has interfered with Claimant's recovery. He believes the knee and back problems are interrelated injuries that must be dealt with together. EX 28 at 22. Until the full course of therapy for the knee and back is completed, addressing stamina, balance, strength and flexibity, Claimant will not reach his maximum recovery for his knee problem. *Id*. at 21-22.

C. Claimant's Back and Dr. Molitor

Christopher Molitor, M.D., the spine specialist, first examined Claimant on March 8, 2000 on referral from Dr. Ling. Dr. Molitor saw Claimant walked with a slow, cautious gait, placing less weight placed on his left leg. Both forward and backward bending (flexion and extension) caused him pain. The doctor saw weakness in Claimant's left gastrocenemius muscle, a positive nerve tension sign, the straight leg raise test was positive (a medical sign of a herniated disc and radiculopathy), and Claimant had some neurological involvement, in the form of a mildly reduced achilles reflexes on the left. EX 27 at 31. The patient's history and exam and led Dr. Molitor to believe Claimant had torn an annulus of a disc (*i.e.,* there was a break in the band of fibrous tissue at the circumference of one of the intervertebral discs) and S1 radiculopathy on the left. EX 4 at 85. The MRI he ordered confirmed an annular tear at the L4-L5 level, with additional longstanding pathology in the low back at the next lower (L5-S1) level. EX 5. To Dr. Molitor, the annular tear "probably explain[ed] most of [Claimant's] symptoms," including the hamstring pain[3]. EX 4 at 82. The "key" treatment recommendation was physical therapy, as Dr. Ling had prescribed. EX 4 at 82.

Annular tears come from the combination of axial (vertical) loading with forward flexion and twisting, that stresses the disc. EX 27 at 39-40. They may cause pain in center of back, plus pain in the buttock and down the back of the thigh, above the knee. *Id*. at 24-5, 44. Hamstring pain (not necessarily radiating in a direct line from the back to the hamstring) is common in disc injuries, and is a sign of an annular tear. EX 27 at 44.

Claimant's fall onto his knee and then to the ground first would compress his spine, especially in view of his height, weight and the distance he fell. He twisted after landing on his knee. He reported hamstring pain at his initial visit to Dr. Ling, so symptoms and signs of a spinal injury were present shortly after the fall, they did not arise only in February 2000, months after the injury, as Employer contends. (*cf., e.g.,* EX 11 at 163). According to Dr. Molitor, the annular tear at L4-L5 was no artifact of Claimant's 1996 back injury. Discs heal poorly if at all. The disc with the damaged annulus had some bulging, but had not lost much height, as it would

[3] The physical therapist, Ms. Hardin, testified that other patients she has treated complained of hamstring pain from a back injury, without pain in the back itself. EX 25 at 23-24. The disc pathology does not commonly cause hamstring pain, but it can.

if the tear were old; there were no irregularities at the vertebral end plates on either side of disc; the associated facet joints had not changed; and the MRI signal showed no changes in the bone marrow. EX 27 at 41-42. In contrast, the MRI did show more obvious chronic change in the form of loss of disc height at the L5-S1 level. That old pathology had caused no work limitations before October 1999, however. *Id*. at 41. The recent annular tear is more likely the pain generator than the long-term L5-S1 changes in Claimant's back. *Id*. at. 25, 43. I find that Claimant's leg pain and later his back pain came from the L4-L5 disc injury he suffered in the fall. *Id.* at 26-7.

I reject the inference the Employer would have me draw that any injury to the back resulted from a bicycle accident in early April 2000, well after Claimant's return to California, when he swerved to avoid a dog. That accident happened a few days before the April 6, 2000 examination done by Dr. Pattison. EX 11 at 163. There is clear evidence of frank back pain by February 2000 in the physical therapist's notes and reports. The MRI of the back Dr. Molitor ordered, which was done on March 15, confirmed the annular tear that Dr. Molitor already had diagnosed from Claimant's clinical presentation at his initial visit on March 8, 2000.

At Claimant's next examination by Dr. Molitor in November 2000, his back symptoms were about the same. Due to intervening defense medical examinations by Drs. Pattison and Richardson, there was disagreement about whether the Employer was responsible for any back treatment. Dr. Molitor's recommendation remained a "diligent exercise program" in physical therapy. EX 4 at 81. He did not see Claimant again until June 2001, when he counseled Claimant to give up longshore work, as it required heavy, repetitive lifting, bending and stooping, but not to limit himself to sedentary work either. EX 4 at 78-79. Strengthening the back muscles was the most likely way for him to obtain relief from pain. EX 27 at 29. Dr. Molitor seems not to have a clear idea of when the physical therapy had stopped, but was not hopeful that additional therapy so long after the fall would be helpful. *Id*. at 32-33. He believed that by June 27, 2001 Claimant's back had reached maximum medical improvement. *Id*. at 34. Nothing led Dr. Molitor to believe that Claimant was malingering. *Id*. at 46.

D. Opinions of Employer's Examiners

Thomas Pattison, M.D., a physiatrist, examined Claimant on Employer's behalf in early April 2000. This was shortly after Claimant's first treatment visit to Dr. Molitor, and the March 15, 2000 MRI of his back. EX 30 (depo.); EX 11(report). On a number of points Dr. Pattison basically agrees with Drs. Ling and Molitor. He found significant objective evidence for Claimant's subjective complaints. EX 11 at 163. Dr. Pattison accepted that the fall was sufficient to cause the condylar damage found during the surgery on the left knee, and to aggravate the annular tear the MRI showed in the L4-L5 disk, even if it did not cause the tear. *Id.*. His views on the mechanism of injury therefore are consistent with those of the treating doctors[4]. He agreed that neither the knee nor back injuries had reached maximum medical improvement. EX 30 at 51. Nonetheless he had questions about causation. He rejected the fall's contribution to the back injury because:

[4] A fall at work that aggravates rather than causes an annular tear would still require the employer to provide medical and indemnity benefits under the Act.

1. He saw no medical record that Claimant had made immediate complaints of back pain. Even making allowances for the fact that Claimant was seen initially at a satellite clinic on a remote island, Dr. Pattison thought back complaints should have appeared before February 2000;

2. Claimant was not forthcoming during the examination about two other falls (one from the bike accident about a week earlier, the other from when his knee locked recently) that likely would have exacerbated his back pain, but Claimant denied either had exacerbated his symptoms;

3. The results of clinical tests at the examination were inconsistent. For example, Claimant gave good effort at grip strength testing, but not in other tests, such as forward bending, or a resistance test to evaluate ankle strength, and

4. Claimant said nothing about prior work injuries to his back.

On balance he did not find Claimant credible, and his report seems to have played a role in the Employer's decision to deny medical care for the back.

The reasons given for doubting Claimant's credibility are unconvincing. Claimant made complaints of hamstring pain, although not frank back pain, at his first visit to Dr. Ling, saying the pain had been present for weeks. Those complaints were signs of the annular tear, and became more significant later, when his back pain increased as the physical therapy for the knee and efforts to strengthen the quadriceps muscle intensified. That pain helped Dr. Molitor diagnose the tear clinically even before the MRI confirmed it. I do not accept Dr. Pattison's view that it would be highly unusual for Claimant to experience pain in the upper left hamstring just below the buttock, without frank back pain. See EX 30 at 47. I accept instead Dr. Molitor's contrary testimony. As Claimant did not contend that either fall in California had injured or worsened his back pain, he had no reason to mention them. Dr. Ling had suggested bicycle riding as a therapy, and physical therapy notes show he often rode a stationary bike as part of his therapy sessions. The fact that Claimant was on a bicycle is unremarkable. His full recovery from the earlier back injuries at Dutch Harbor, with no residual limitations, and the ability to do a wide range of longshore work before the fall, adequately explains Claimant's failure to mention healed back injuries that were about three years old. They had no ongoing relevance in his mind. The failure to mention them is no evidence of mendacity.

The fundamental problem with Dr. Pattison's analysis is that the Act provides a presumption of coverage that requires more than skepticism to rebut.

Fred Richardson, M.D. examined Claimant on Employer's behalf once, on July 27, 2000, and authored three reports, dated July 27, 2000, Oct. 12, 2000 and Jan. 3, 2001. EX 29, internal Ex. B. For his first report he reviewed certain medical records through early June of 2000, and a Health Questionnaire Mr. Earnshaw filled out before the examination. EX 29, internal Ex. C. He did not review additional records for his next two reports.

Dr. Richardson saw Claimant had an imbalanced gait, favoring the left lower extremity, much as Dr. Molitor had seen on March 8, 2000. On physical examination Claimant had lost at least 5 degrees of flexion of the left knee; and was able to squat only in a slow, deliberate manner, by bearing more weight on the right than left leg. EX 29, internal Ex. 32 (report of July 27) at 6. This is consistent with the physical therapy notes. Dr. Richardson felt grinding behind both kneecaps as the knees were moved, worse on the left than the right. He concluded Mr. Earnshaw reached maximum medical improvement from his knee injury on June 29, 2000, with some permanent impairments. EX 29 at 15, 59-60.

He wrote his second and third reports due to confusion about which edition of the *AMA Guides to the Evaluation of Permanent Impairments* (*AMA Guides*) he should use to rate loss of use in Claimant's lower extremity. *Id*. at 16-17. The greater part of his deposition deals with computing a rating under the fifth edition of the *AMA Guides*. While he first thought Claimant had a 12% lower extremity impairment his final conclusion was that Claimant had a 5 % permanent impairment of the lower extremity, due to complaints of patelofemoral pain and crepitation on physical examination, unaccompanied by x-ray evidence of joint space narrowing. *AMA Guides,* fifth ed. at 544; EX 29 at 42, 61. This 5% rating gives no effect to Claimant's gait derangement or the loss of flexion he found.

I am unpersuaded by Dr. Richardson's views, in part because he relied on an incomplete medical record. He also focused so narrowly on the knee that it appears he never considered whether a back injury might be impeding the rehabilitation of Claimant's knee. His July 2000 medical records review could not have considered the notes Dr. Ling and Molitor wrote later, especially those of November 2000. But he gave even those he had short shrift, virtually ignoring the back problem. He does not acknowledge the letter Dr. Ling wrote on May 1, 2000 finding the back and knee injuries work related, or the letter of May 11, 2000 in which Dr. Ling stated that the back had to be stabilized for the knee to reach maximum improvement. EX 2 at 29, 28. His summaries of Dr. Molitor's reports are superficial. For example, he says that in the March 8, 2000 report, Dr. Molitor did not "attempt to distinguish the abnormalities that he refers to the left lower extremity as being related to the lumbar or left knee pathology." EX 29, internal Ex. B (Report of July 27, 2000) at 3. Rather than entertain the possibility the back and knee problems were interrelated, as Drs. Ling and Molitor believed, Dr. Richardson dismissed any contribution without analysis. This hardly rebuts the contentions of the treating doctors.

The July report mentions but accords no significance to the finding of the physical therapist, Ms. Hardin, that by early February 2000 the good early progress Claimant had made in therapy was interrupted by back pain - pain that left him unable to give a very good effort to his knee rehabilitation. EX 29, internal Ex. B, at 4, ¶ 16 of Dr. Richardson's Review of Medical Records. He also appears to have paid no attention to Claimant's answer to the health questionnaire he had asked the Claimant to complete just before that examination, which asked among other things whether current treatment was helpful. Claimant answered that problems with his lower back were prolonging his recovery. EX 29, internal Ex. C at 3.

Finally, Dr. Richardson does not give a very specific or persuasive reason for concluding that Claimant had reached maximum medical improvement at the time of his examination. He seems to say it is because Claimant did not think his symptoms had been improving much. Dr. Pattison did not believe Claimant had reached that status in April 2000. Dr. Richardson

identifies no changes between April and June as a basis for his declaration, and makes no effort to deal with the fact that the treating surgeon had not found that Claimant had reached that status. An unexplained declaration of maximum improvement means little to me. Dr. Ling's reasons for finding Claimant had not attained maximum improvement are more persuasive.

E. Opinions of Employer's Non-Examining Evaluator

Charles Brooks, M.D. reviewed the records, but did not examine Claimant. His opinion is found in a report with a cover letter dated January 22, 2001 (EX 8), supplemented by his depositions of December 2003 (EX 31) and February of 2004 (EX 32).

The conclusions he reaches are heavily colored by the conviction that Claimant lacks credibility, a conviction I do not share. EX 8 at 140. He sees symptom magnification in the Claimant's reports of his condition throughout the record, and discerns a sort of injury inflation in Claimant's descriptions of the height of the fall as time progressed, from 6 feet when first seen at the Iliuliuk Clinic, to 7 feet at his first visit to Dr. Ling, to 8 feet when he was questioned by Dr. Molitor, and finally to 9 feet when he was evaluated by Dr. Richardson. These differences are not so great as the make me doubt the basic truth of the account of the fall. He also believes the Claimant was not forthright about disclosing prior injuries. By the nature of the heavy exertion[5] involved in longshore work at Dutch Harbor over eight years, Claimant did have prior injuries, for example a 1996 injury to his back at the L5-S1 level. He did not mention them at examinations because he had recovered from them fully, without any ongoing limitations. I find this explanation persuasive, as I explained in discussing the report of Dr. Pattison. At the time of the fall Claimant was performing a range of longshore work. I find the testimony of the treating doctors the most convincing, and accept that the fall caused the condylar impairments, the annular tear, and generated the hamstring and other back pain that interfered with the physical therapy prescribed for the knee.

Dr. Brooks believes the fall permanently worsened chondromalacia that already was present in Claimant's knee before the fall. EX 31 at 27. Yet he also concluded a fall onto the patella would not worsen chondromalacia of the weight bearing portions of the medial femoral or the tibial condyles - the surfaces Dr. Ling repaired in the December 1999 arthroscopic surgery. To him, no more than 4 weeks of physical therapy would have been appropriate treatment for the fall onto the kneecap, without surgery. He appears to be the only physician to hold this opinion, as neither Drs. Pattison nor Richardson questioned the relationship between the fall and the condylar damage, and Dr. Richardson testified that he did not believe the surgery had been inappropriate. EX 29 at 45-46. I accept the weight of medical opinion, that the surgery was appropriate. Dr. Brooks' analysis does not convince me that everyone else was wrong on this point.

[5] The Secretary's system for rating physical capacities required to do the job in the Dictionary of Occupational Titles categorized the work as " very heavy." (See the exhibits associated with Dr. Haag's testimony). Claimant's ability to do a wide range of very heavy jobs before his fall supports his testimony that he had fully recovered from any earlier injuries. There were no ongoing limitations to tell treating or examining doctors about. Claimant's reason for not mentioning those earlier injuries has been adequately explained; I do not regard the failure to mention them as proof of mendacity, or that he has been untrustworthy in reporting his symptoms. *See*, *Harrison v. Todd Pacific Shipyards Corp.*, 21 BRBS 339 (1988).

Dr. Brooks also doubts the back condition is related to the fall, largely due to the absence of contemporaneous complaints of back pain to the nurses or physician's assistant at the Iliuliuk Clinic on the three occasions Claimant was seen there. He also doubts that falling into a prone position would create the annular tear. EX 8 at 145-48. He seems alone in this opinion as well; Dr. Pattison did not dispute the mechanism of the back injury. Dr. Brooks concurs that the evaluation and treatment ordered by Dr. Molitor were appropriate, and approves an ongoing exercise program as the best way to improve Claimant's the low back condition, which he did not believe had reached maximum medical improvement when he wrote his report. *Id.* at 149. In terms of limitations, he believes the Claimant was precluded from the heaviest types of longshore work following the 1996 back injury. *Id.* at 148. This is somewhat surprising, as Claimant never regarded himself as having limitations in the work he could do before his fall.

This evidence highlights the common fact that medicine is an art and a science. Competent physicians can hold quite divergent views about the causes of pain and appropriate treatment for it. The Secretary of Labor is not an injured workers' medical guardian, deciding what treatment he or she ought to have. My role is not to determine whether Dr. Brooks' views about surgery and therapy are better supported than those of the treating physicians, Drs. Ling and Molitor. It is not the insurance adjuster's role either. These are precisely the issues the decision in *Amos v. Director, OWCP,* 164 F.3d 480 (9th Cir. 1999) (amended opinion) forbids me to become involved in. Evidence from Dr. Brooks does not prove that the treatment decisions of the doctors Claimant chose to care for the injuries he suffered in the fall were beyond the pale of the debatable.

F. Vocational Evidence

Claimant has not worked since he left Alaska in late October 1997 because he had not been released to go back to work. TR 48-49. The Employer's vocational evidence included a job survey done by Michael Haag, Ph.D., offered to show both that Claimant could return to his past work in Dutch Harbor, Alaska, and perform alternative work in the Placerville, CA area. I reject the testimony that Claimant could return to longshore work in Alaska.

Dr. Haag's synthesis of the reports and deposition testimony of Drs. Molitor and Dr. Brooks led him to conclude Claimant could perform the jobs of top pick operator, loader operator, checker, and forklift operator with his back condition. Drs. Molitor and Brooks believed that with his history of prior back injuries, Claimant should not engage in the strenuous lifting done by a warehouse worker or "longshoreman" described in the Alaska job analyses Dr. Haag had reviewed. TR at 94-95. Because Claimant had lost his relative seniority known as "B card" registration with the ILWU, he could not expect to obtain commonly the skilled, less physically demanding driving jobs he had obtained when he was injured. He would have to return to the lower status of a casual laborer he held when he first began longshore work in Alaska, and take the unskilled very heavy jobs both doctors have precluded. But even if I assumed that he lost his seniority due to his own fault (late payment of his union fees while he was out of work due to this injury) he could not return to the work required in Dutch Harbor. As a small and remote work site, workers with enough seniority to obtain driving job on a given day still must assist in other heavy physical jobs, such as lashing, that need to be done during a shift. TR 156-57. Skilled and laboring jobs are not as neatly separated as Dr. Haag believes, or work records imply. Moreover, no current labor agreement would allow Claimant to work in

California ports, based on his registration as a union member working in Dutch Harbor. TR at 119.

I also doubt Dr. Haag's assumption that when skilled driving jobs such as top pick operator were available to Claimant, he would have the opportunity to relieve back pain from prolonged sitting by getting out of the cab, walking out on a little walkway next to the cab or stand on the ground to stretch at least every hour to hour and a half. TR 106. The press of work simply does not permit that reliably. TR at 160-61. Claimant is not capable of returning to his pre-injury longshore work.

Dr. Haag also testified about unskilled jobs he believed were available to Claimant in California. They required no vocational preparation or training period, and he believed they were within Claimant's physical abilities. TR at 116-17; EX 20. The alternative jobs Dr. Haag proposed assumed the ability to work a regular 40-hour week, or at least he did not posit in his discussions with potential employers that Claimant would be absent regularly for physical therapy[6]. TR at 127-8. This is a significant omission, for I find Claimant is entitled to medical care for his back (which had been denied) and knee (which had been impermissibly limited) under § 7 of the Act. For the four to six month aggressive course of physical therapy Dr. Ling has prescribed, medical care will be Claimant's primary focus. The evidence fails to show that the potential employers Dr. Haag identified would accommodate regular absences for treatment by a new employee in an unskilled job, and I will not assume in the absence of proof that they would do so. The jobs Dr. Haag identified are not ones Claimant could reasonably compete for.

Finally I reject Dr. Haag's opinion that Dr. Ling did Claimant a disservice by not finding Claimant had reached maximum medical improvement. TR at 110-111. Whether Claimant required the physical therapy the treating surgeon ordered but the insurer countermanded is a medical decision, not a vocational one. This sort of overreaching into medical issues causes me to regard Dr. Haag's views on this matter as lying outside his expertise, and too partisan to accept at face value.

Employer has failed to demonstrate that suitable alternative employment was realistically and regularly available to Claimant.

G. Penalty.

The claim for penalties under § 14(e) of the Act proceeds on a mistaken premise. Claimant would treat the lump sum of $14,916.94 Employer paid to him, based on the 12% lower extremity impairment rating Dr. Richardson[7] gave, as a prepayment of his weekly benefits. At his stipulated weekly compensation rate of $656.72, the prepayment would cover nearly 23 weeks of benefits. Thereafter he says his benefits have not been paid timely, so a penalty accrued.

[6] Whether the aggressive course of physical therapy Dr. Ling has in mind would be twice or three times a week is not clear to me, but either involve significant weekly absences from an unskilled job.

[7] Employer says Dr. Brooks' 5% rating is correct, and the difference between it and what it paid under Dr. Richardson's 12% rating constitutes an overpayment.

The parties stipulated that the controversion Employer filed was timely. Claimant is due more money, but the controversion cut off any right to a penalty. *Frisco v. Perini Corp*., 14 BRBS 798, 800 (1981). What Claimant receives for delay is interest on those weekly benefits from the time they were payable. *Foundation Constructors v. Dir., OWCP*, 950 F.2d 621, 625 (9th Cir. 1991); *Nat'l Steel & Shipbuilding Co. v. Bonner*, 600 F.2d 1288, 1294 (9th Cir. 1979); 28 U.S.C. § 1961.

H. Attorneys Fees.

Claimant has successfully prosecuted this matter and is entitled to attorney's fees and costs under § 28 of the Act.

II. Conclusions of Law

A. Section 20(a) presumptions and causation

The Act's no-fault approach to liability abolished common law defenses that had been available to employers, and awarded workers less compensation than tort law had. *See*, Sections 4(b), 5(a), and 8 of the Act. Workers became entitled to prompt medical care and indemnity benefits for on-the-job injuries under this Congressional balancing of rights. *Potomac Elec. Power Co. v. Director, OWCP*, 449 U.S. 268, 281 & nn. 23 and 24 (1980); *Cardillo v. Liberty Mut. Ins. Co.,* 330 U.S. 469, 476 (1947); *Newport News Shipbuilding and Dry Dock Co. v. Brown,* 376 F.3d 245, 250 (4th Cir. 2004).

No doctor denied the fall injured Claimant's left knee; they disputed the extent of the injury. Claimant enjoyed an initial presumption that the fall could have caused, or aggravated his back impairments, especially when the annular tear seen on the MRI could be responsible for his back and hamstring complaints. *See,* Section 20(a) of the Act; *Merrill v. Todd Pac. Shipyards Corp.,* 25 BRBS 140 (1991); *Gencarelle v. Gen. Dynamics Corp.,* 22 BRBS 170 (1989), *aff'd,* 892 F.2d 173, 23 BRBS 13 (CRT)(2d Cir. 1989). This proof shifted the burden to the Employer to rebut the presumption with substantial countervailing medical evidence. *Merrill,* 25 BRBS at 144. It did so with the evidence of Dr. Brooks with respect to the back. *Duhagon v. Metropolitan Stevedore Co.,* 169 F.3d 615, 33 BRBS 1(CRT) (9th Cir. 1999)*, aff'g.* 31 BRBS 98 (1997) (holding a doctor's opinion that a claimant's pre-existing back condition was not aggravated by a later accident rebutted the Section 20(a) presumption, when the doctor pointed to specific record evidence to support his opinion). The testimony and reports of Drs. Pattison and Richardson were not adequate to contradict the presumption.

The statutory presumptions about causation have fallen out of the case with respect to the back. I must decide whether the evidence as a whole demonstrates that the back injury was caused by work. See *Del Vecchio v. Bowers,* 296 U.S. 280 (1935). I find it was. Dr. Molitor's interpretation of the MRI results as showing a recent annular tear that was responsible for the back complaints is persuasive. It is more probable than not that the fall caused the tear, and Claimant's back symptoms for the reasons he articulated.

B. Section 7 medical care

Claimant's knee and back require additional, interrelated medical care. Employers are

obligated to provide injured workers with "medical, surgical, and other attendance or treatment . . . for such period as the nature of the injury or the process of recovery may require." 33 U.S.C. § 907(a). Workers are free to choose a physician "to provide medical care under this Act". *Id*., § 907(b). That statutory right is hollow if the treatment recommendations of the chosen physician carry no weight. The decision of the Ninth Circuit in *Amos v. Director, OWCP,* 164 F.3d 480 (9th Cir. 1999) (amended opinion), requires employers and adjudicators to accept treatment decisions claimants reach in consultation with their treating physicians. This rule is grounded in the quoted subsections of § 7, and the Act's humanitarian purposes, but is not found in the text of § 7 or in any of the Secretary's implementing regulations. Under *Amos*, the physical therapy Dr. Ling prescribed and Dr. Molitor wanted Claimant to have should have been provided without interference by the insurance adjuster, review by the OWCP, or any adjudication at this or any other level.

1. *Amos* deference

The deference *Amos* required to treatment decisions has aspects of a rule of convenience, something commonplace in Longshore jurisprudence. For example, the Second Circuit based the rule that saddles the last employer to expose a worker to injurious conditions with sole liability for benefits on the over-riding importance Congress gave to efficient administration of benefits under the Act. *Travelers Ins. Co. v. Cardillo,* 225 F.2d 137, 145 (2d Cir. 1955). The Ninth Circuit recognized this when it adopted *Cardillo* in *Cordero v. Triple A Machine Shop*, 580 F.2d 1331, 1336 (9th Cir. 1978). The *Cardillo* rule has become a firmly embedded principle that is consistently applied. *See*, *e.g., Metropolitan Stevedore Co. v. Crescent Wharf and Warehouse Co. (Price)*, 339 F.3d 1102 (9th Cir. 2003) and *Kelaita v. Dir., OWCP,* 799 F.2d 1308, 1311 (9th Cir. 1986). As a corollary, employers may not delay medical care and indemnity payments to injured workers while they litigate which of several employers is liable for those benefits. *Todd Shipyards Corp. v. Black*, 717 F.2d 1280, 1285 (9th Cir. 1983) (relying on *Cardillo*). When it is unclear which employer was the last to expose a claimant to injurious conditions, liability may be allocated to the employer the worker files his claim against. *Gen. Ship Serv. v. Dir., OWCP,* 938 F.2d 960, 962 (9th Cir. 1991). *Amos* is consistent with the approach taken in all these decisions. The Congressional goal of ensuring workers prompt medical treatment is frustrated if employers may challenge reasonable but debatable decisions about acute and rehabilitative care through four levels of adjudication (an informal conference, a trial before an administrative law judge, and review by the Benefits Review Board and U.S. Courts of Appeals). Withholding treatment prolongs a worker's recovery, as it has here.

The *Amos* decision relied not only on the two subsections of § 7 of the Longshore Act, but also on decisions interpreting the Social Security Act's disability program. The two acts provide disability benefits in very different ways. Longshore indemnity and medical benefits are due almost immediately upon a work-related injury, and workers enjoy a presumption of coverage. 33 U.S.C. §§ 914(b), 920(a). In contrast, Social Security disability benefits are not available so promptly. Title II of the Social Security Act insures those who have earned enough quarters of coverage against long term (rather than short term) disability, if they satisfy exacting medical and vocational criteria. They must prove severe physical or mental impairments have left them unable to engage in any substantial gainful activity for a period of at least 12 consecutive months. 42 U.S.C. § 423(d)(1)(A). Congress postponed their monthly benefit payments with an additional five-month waiting period. 42 U.S.C. § 423 (a)(1)(D)(i) and (c)(2).

Medicare part A hospital insurance benefits do not begin until 24 months after disability income benefits are payable, *i.e.,* 29 months after the disability began. 42 U.S.C. § 426(b)(2)(A)(i).

Social Security regulations create a hierarchy of medical sources, whose opinions are progressively more significant in evaluating disability applications. The opinions fall into two broad categories: whether an applicant suffers from severe, medically determinable impairments, and what the applicant still can do in spite of them. The Commissioner of Social Security provides no medical treatment as part of a disability determination, so the opinions her adjudicators consider do not involve treatment recommendations. Under 20 C.F.R. § 404.1527(d)(2) (2004), Social Security adjudicators give most (though not necessarily controlling) weight to opinions of treating doctors[8] who provide a detailed, longitudinal view of the applicant's impairments; less weight to opinions of examining doctors who never treated the applicant, or did so only in brief hospitalizations; and least weight to opinions of nonexamining doctors who only reviewed records. The longer the treatment relationship has endured, the more often the doctor has seen the patient, and the more specifically the doctor supports an opinion, the more valuable it is. *Id.* at § 404.1527(d)(2)(i), (ii).

The treating physician rules under the Longshore Act and the Social Security Act have different purposes and statutory or regulatory bases. None of the differences undercut the central holding of *Amos,* that decisions about treatment are reserved to injured workers and their treating doctors.

2. The *Black & Decker* Decision

The Employer argues that the deference *Amos* requires to the treatment decisions a claimant and his doctor reach did not survive the decision of the U.S. Supreme Court in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003). Regulations of the Secretary of Labor require ERISA plan[9] administrators to make full and fair assessments of claims presented for benefits under employee welfare benefit plans. 20 C.F.R. § 560.503-1 (2002). *Black & Decker* rejected the Ninth Circuit's additional requirement, which no statute or regulation imposed, that an ERISA administrator had to give specific reasons, based on substantial evidence in the record, to reject a treating physician's medical opinion about a disability claim. 538 U.S. at 825 & n. 1. The Ninth Circuit effectively had created a preference for the treating doctor's opinion, because the administrator had no similar duty to analyze or rebut opinions received from doctors the plan sent the applicant to for a disability evaluation. It had drawn its rule from decisions applying or interpreting the Social Security regulation that requires its adjudicators to give special deference

[8] Sources are generally but not necessarily medical doctors, the term can include osteopathic doctors, licensed psychologists, optometrists, podiatrists, or speech-language pathologists, depending on the impairment involved. 20 C.F.R. § 1513(a) (2004).

[9] These are unique benefit plans employers craft for their employees, and administer under the Employment Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq*. Black & Decker's plan told its administrator to ground disability decisions in "suitable medical evidence and a review of the Participant's employment history that the [administrator] deems satisfactory in its sole and absolute discretion." 538 U. S. at 826. An administrator is unconstrained by the statutes and regulations administrative law judges and courts follow in making determinations under the nationwide disability programs of the Social Security Act or the Longshore and Harbor Workers' Compensation Act.

to findings and opinions from treating physicians[10]. 20 C.F.R. § 404.1527(d)(2) (2002). Medical treatment the plan participant might be entitled to receive was not at issue.

In abrogating the Ninth Circuit's application of a treating physician rule to ERISA disability determinations the Supreme Court noted, without criticism, that the federal courts of appeals require administrative law judges in Longshore disability compensation cases to accept a treating physician's opinion about the existence of a disability. 538 U.S. at 830 & n. 3 [citing the Second Circuit's opinion in *Pietrunti v Dir., OWCP*, 119 F.3d 1035, 1042 (2nd Cir. 1997)]. Both Drs. Ling and Molitor believe the fall caused the annular tear that produces Claimant's back pain, and that successful treatment of his injured knee requires treatment for the back as well. *Amos* controls a different issue, not whether a disability exists, but whether an Employer may delay or deny physical therapy a treating surgeon has prescribed under § 7 of the Longshore Act in an adjudicatory challenge. *Black & Decker* says nothing about whether § 7 of the Longshore Act gives weight to reasonable but debatable treatment decisions injured workers reach with their doctors. *Amos* remains good law.

C. The Nature and Degree of Claimant's Disability

The Employer's failure to provide any back treatment under § 7 of the Act leads me to reject the idea that Claimant's back has reached maximum medical improvement. Dr. Ling is adamant that back treatment will be necessary to maximize recovery from the knee injury. I have not overlooked Dr. Molitor's opinion that the delay in making back treatment available reduces the likelihood that delayed treatment will prove efficacious. Whether the therapy that Dr. Ling and Molitor ordered or advocated will reduce or relieve back pain now, and permit Claimant to gain additional knee function through improved stamina, balance, strength and flexibility is an empirical question. At some point the treating doctors may conclude the effort is futile, but Claimant made progress in the past in his physical therapy program, and should have the opportunity to have the care Employer should never have withheld. He also should have the functional capacities examination Dr. Ling has advocated after he attains maximum medical improvement. Claimant has not reached maximum medical improvement for his knee or back injuries, and remains temporarily disabled in the Act's taxonomy. *Stevens v Dir., OWCP*, 909 F.2d 1256 (9th Cir. 1990).

Claimant cannot return to his former longshore work, for the reasons given for rejecting Dr. Haag's testimony. Had his treating physician released him to work before he reached maximum medical improvement, earnings from jobs realistically and regularly available to him would be set off from his average weekly wage. *Berezin v. Cascade Gen.,* 34 BRBS 163, 166 (2000). But Dr. Ling never gave that release.

Employer failed to show Claimant's disability is a partial one, by demonstrating suitable alternative employment, given the limitations the ongoing aggressive program of physical therapy will impose on his availability for work. *Stevens, supra*, 909 F.2d at 1260. Claimant

[10] For a generalist appellate court, there is no doubt a tendency to look for commonalities in disability adjudications that come to it for review, whether they arise under the Social Security Act, the Longshore Act or ERISA. "A rose is a rose is a rose," in Gertrude Stein's famous line. But *Black & Decker* found semantics do matter, and disability adjudications under the Social Security Act and ERISA are not all that similar.

stipulated that he could earn at least $8.25 per hour, and would earn $330.00 per week at such work. He also maintained that he ought to have the therapy that his treating physicians wanted him to have. The stipulation does not say that he could actually work 40 hours per week while receiving physical therapy, and Dr. Haag did not tell the employers he surveyed about any regular absences or limitations in the hours Claimant would be able to work. Employer failed to show a reasonable likelihood that Claimant would be hired if he diligently sought the job(s) identified. *Hairston v. Dir., OWCP*, 849 F.2d 1194, 1196 (9th Cir. 1988); *Bumble Bee Seafoods v. Dir., OWCP*, 629 F.2d 1327 (9th Cir. 1980) (showing a claimant is physically able to perform work at a certain exertional level is insufficient to show all jobs at that level are available to him).

Claimant has been temporarily totally disabled since his fall, and Employer owes the stipulated weekly compensation rate of $656.72 since the date of injury, plus interest on installments not paid when due. Unlike the five year limit on temporary partial disability payments found in § 8(e) of the Act, there is no statutory cap on a period of temporary total disability.

III. Order

It is hereby ORDERED that:

1. Employer shall provide medical benefits under § 7 of the Act for the left knee and back injuries Claimant sustained on October 11, 1999. This includes the physical therapy prescribed by the knee surgeon, and a functional capacities evaluation after the Claimant reaches maximum medical improvement.

2. Employer shall provide compensation to the Claimant at the stipulated weekly rate of $656.72 from October 27, 1999 forward, plus interest at the statutory rate set in 28 U.S.C. § 1961 for all installments of temporary total disability not paid on the dates due.

3. Claimant has been temporarily totally disabled from October 27, 1999 forward. He has not reached maximum medical improvement, cannot return to his prior job, and employer failed to establish that suitable alternative employment is available.

4. Employer is entitled to a credit for the lump sum payment of $14,916.94 it made, for what it believed was the scheduled amount due under § 8(c) for a 12% loss of use of the left lower extremity.

5. The District Director is authorized to make and adjust any calculations necessary to implement this order.

6. Claimant must petition for attorney's fees and costs within 20 days after service of this Decision and Order by the District Director. The petition must be prepared on a line item basis and comply with 20 C.F.R. § 702.132 (2004). Employer may object to any line item within 10 days after receiving the petition. All objections must be explained by reference to the relevant line item, or the item will be treated as accepted by Employer,

and allowed. Claimant may file a line item reply within 10 days after receiving any objections. Claimant's counsel shall arrange a meeting within 10 days thereafter, at which counsel for both parties will attempt to resolve all objections. The meeting may be in person or by telephone. Claimant's counsel shall file a report 10 days after the meeting explaining which objections have been resolved, and identifying any that remain for decision.

A

WILLIAM DORSEY
Administrative Law Judge

WRD